GUIDELINES FOR PGY-1 RESIDENTS (INTERNS)

I. General

During the PG1 year, the resident physician is expected to develop into a competent internist. The following guidelines outline the fundamental responsibilities of the PG1 residents or "interns" in Internal Medicine at David Grant Medical Center. The senior resident and staff attending physician on each rotation are the intern's primary supervisors and educators and may designate any additional guidelines they deem necessary.

II. Rotations

A. Inpatient Ward: Each intern will spend five to six 4-week blocks on the inpatient ward. One of these ward blocks will be on the UC Davis Inpatient Medicine Ward.
B. ICU: Each intern will spend two to three 4-week blocks in the ICU.
C. ED: Each intern will spend one 4-week rotation in the Kaiser-Vallejo Emergency Department.
D. Outpatient Rotations: Each intern will spend one to one and a half 4-week rotation in the Acute Medicine Clinic, one 4-week rotation in Geriatrics, one 4-week rotation in Women's Health, and one 4-week rotation in Cardiology.

III. Inpatient Medicine (Wards & ICU)

A. Ward and ICU Team Structure:
    a. Each ward intern works as part of a "ward team" which includes that intern, a PG2 or PG3 resident ("ward resident"), a staff internist or medical subspecialist ("attending physician"), and an occasional medical student.
    b. The C team consists of a Family Practice intern, two PG2 family practice residents, and a staff internist.
    c. All intensive care (MICU/CCU) patients are admitted to the interns on the A (MICU/CCU) team. The A team consists of 3 interns and a PG2 or PG3 resident. There will be both a cardiologist and a pulmonologist in the ICU as attending physicians.
B. Goals and Objectives:

a. The goals and objectives of the ward and ICU rotations must be reviewed with the resident at the start of each rotation. Goals should reflect the core competencies for Internal Medicine as defined by the American Board of Internal Medicine (ABIM) and the Accreditation Council for Graduate Medical Education (ACGME) as well as those put forth by the attending physician, resident, and intern.

C. Intern Responsibilities and Supervision:
    a. The intern is responsible for the day-to-day evaluation and care of all assigned patients and functions as the primary physician.
    b. With few exceptions, the interns should write all orders. However, residents must co-sign all admission, transfer and discharge orders during the first three months of the academic year.
    c. The ward or ICU resident, as well as the attending physician, closely supervise the activities of the intern. The ward or ICU resident should provide any and all

assistance needed and should be available to the intern at all times while the team is on-call.

d. The intern should keep the ward resident and attending physician informed of all significant developments occurring in patients under his/her care. Final authority and responsibility for patient care resides with the attending physician.

e. Every block on the wards or in the ICU, the resident and the attending physician should observe each intern at least once as they perform a complete history and physical examination, and offer constructive feedback.

D. Call:

a. Each ward intern is responsible for in-house call every fourth night.

b. Post call duties end at noon the following day (signs out to on-call intern and leaves the hospital).

c. Call starts at 0800 and ends at 0800 the next day.

d. When on-call the intern is responsible for the management of admissions assigned to him/her as well as the care of urgent problems that develop in patients followed by other ward teams (if the intern is on ward call) or other ICU interns (if the intern is on ICU call).

E. Admissions and Transfers:

a. No ward or ICU intern may accept more than 5 full admissions in any 24-hour period or 8 in any 48-hour period. The ward resident, ICU resident, or other staff will perform any history and physicals (H&P's) in excess of 5. The intern may not be responsible for more than 10 inpatients at a time.

b. The intern must accomplish the initial evaluation of all assigned patients a soon as possible following admission.

c. The initial evaluation will include a complete medical history and review of medical records, a physical examination (including rectal and pelvic examinations as needed), and appropriate radiographic and laboratory studies. The data obtained will be recorded on the H & P form.

d. When a patient is admitted who receives outpatient internal medicine care at David Grant USAF Medical Center, it is important that the intern promptly inform the patient's outpatient Internal Medicine physician. In addition, if a patient has had recent surgery, the appropriate surgical subspecialist should be consulted.

e. When a patient followed by an intern in Outpatient Continuity Clinic is admitted by the on call team, the care of that patient will be transferred to the outpatient intern the next morning provided that intern is currently on another ward team. The goal of this is to maintain continuity of care.

f. Patients readmitted to the hospital that have already been on a ward team that block will be admitted and transferred to the prior intern for continuity of care the following morning. Exceptions to this rule are available in extenuating circumstances at the discretion of the ward resident on call.

g. Transfers occurring between the ICU/CCU and the wards are coordinated through the resident on call. Transfers from the ICU will return ("bounce back") to the ward team from whence they came (exceptional cases mediated by the ward resident on call).

h. The above admission and transfer policies are guidelines only and may be altered at the discretion of the Chief of Residents to cover special situations as they arise.

F. Inpatient Record: The intern is responsible for maintaining the inpatient record in a timely organized, complete, and legible fashion.
    a. H&P's:
        i. An H&P must be written on all new admissions. A carefully written problem oriented assessment must conclude each admitting note. This assessment should include a complete problem list, a systemic consideration of the differential diagnosis for each problem, and a discussion of possible diagnostic and therapeutic approaches. The assessment should, at the minimum, reflect the fund of knowledge available in a standard textbook of internal medicine.
        ii. If the intern is not on call, this must be accomplished before the intern leaves the hospital for the day. If the intern is on call, within 24 hours.
        iii. If a full H&P has been written on the patient within the last 30 days, an interim note will suffice provided a photocopy of the prior H&P is on the chart. A written physical examination and interim assessment is always required.
        iv. The short form may be used on patients admitted only for specific procedures, i.e. broncoscopy, endoscopy, cardiac catheterizations, transfusions, etc, as long as the hospital stay is less than 3 days and includes no complications of therapy.
        v. An H&P or at least a preliminary admit note and orders should be written on ICU/CCU patients before the intern and resident leave the unit. Exceptions will be considered for urgent patient care situations on an individual basis.
    b. Progress Notes:
        i. Progress notes will be written on all inpatients at a minimum of every day. When on-call a minimum of one progress note for the 36-hour call period must be written.
        ii. Specific symptoms, signs, and laboratory tests pertinent to active problems are monitored and recorded to provide a clinical index of progress in the hospital and to ensure early recognition of complications.
        iii. The assessment for each problem should include refinements of previously documented differential diagnosis as new information becomes available, acknowledgment of consultant opinions, explanations of deviations from original plans or consultant recommendations, and contingency plans for possible complications.
    c. Procedure Notes:
        i. A procedure note will be written promptly for each invasive procedure.
        ii. The notes should specify that informed consent was obtained and possible risks explained to the patient, the type of anesthesia, the approach used, the findings, (e.g. appearance and volume of fluids obtained), the disposition of the specimens, and the occurrence or lack of complications. Results of cell counts, chemistries, and stains obtained on all body fluids (CSF, peritoneal, pleural) should always be recorded on the same day of the procedure.
        iii. Transfusion of blood products requires a specific note documenting indications and risks, and also a post-transfusion note detailing outcome.

d. Off Service Notes:
    i. When a patient's care shifts from one physician to another by inpatient transfer or change of service, the intern giving up care of the patient must write a summary note.
    ii. This "Transfer Note" or "Off Service Note" should be written in a problem oriented format and should include an updated problem list, a medication list, a brief summary of the clinical presentation and hospital course, pending test results, and the current plan of management as well as current exam and pertinent data. Off Service notes may be dictated and an ICU interim summary should be dictated.
    iii. The intern assuming care of the patient should write a "Transfer Acceptance Note" or "On Service Note" in similar fashion.
e. Incident Reports:
    i. The intern should identify medical quality assurance occurrences that require activation of AF Form 2519 (“Incident Report”).
    ii. In addition, if a patient is examined for an Incident Report a note should be written in the inpatient record documented that the patient was seen and examined but should not refer to the Incident Report as this is an internal document which is not part of the medical record.
f. Discharge Notes:
    i. The intern will write a discharge note for each patient in the inpatient chart and a written narrative summary at the time of discharge. A dictated narrative summary is mandatory for patients staying 7 or more days, or for patients whose hospital stay included time in the ICU.
    ii. The original discharge form is placed in the inpatient record and a copy is given to the outpatient physician.
    iii. A copy of the discharge form should also be given to the Internal Medicine nurses and a consult sent to them through CHCS so that they can call the patient for f/u. The Internal Medicine nurses will ensure that the patients are taking their medications properly and understand the discharge instructions. In addition, they can monitor specific problems of concern such as shortness of breath in a patient discharged for COPD exacerbation, etc.
    iv. The discharge form should include: the list of diagnoses with the primary diagnosis at the top; list of procedures; dates of admission and discharge; brief narrative of initial presentation, hospital course, and condition on discharge; test results pending; medications; diet; activities; follow-up appointments; and the statement "Narrative Summary Dictated" if done.
    v. The intern should request that a copy of each dictated narrative be sent to the patient's out patient physician.
    vi. A follow-up appointment should be booked with the patient’s outpatient physician. If this cannot be accomplished then a member of the inpatient team should see the patient in follow-up. Hospital follow-ups should not be booked in the Acute Medicine Clinic.
    vii. If a patient is transferred to another treatment facility such as a nursing home, the discharge summary should be dictated and sent with the patient. Nursing home patients also need a copy of the H&P, recent CXR and labs

if done. Some nursing homes require transfer orders and filled prescriptions from the discharging facility.

g. Advance Directives and Code Status: Advance directives and code status should be addressed with every patient admitted to the hospital and documented in the chart.

h. Death Notes:

i. When a patient dies on the Medical Service, the resident must write a "Death Note" delineating the circumstances surrounding the patient's death, final diagnoses, and whether consent for autopsy was obtained.

ii. Only the ward PG2 or PG3 dictates death summaries.

i. MEB's and TDRL's: The ward PG2 or PG3 resident dictates narrative summaries for all MEB and TDRL patients.

j. Consults:

i. When a subspecialty consultation is desired, the exact nature of the problem and the specific questions being asked of the consultant should be clearly stated on the consultation sheet, SF 513. The appropriate person on the consult team should then be called.

ii. The ward resident should approve all consultations.

k. Cross Cover Notes: When patients on other ward teams are evaluated or treated by the on call intern, that intern will write a problem oriented "Cross Coverage" note.

l. Medical Records: Each intern is required to visit Medical Records at least once a week to dictate, sign, or review any medical records that have been completed. Leave will not be permitted if any records are outstanding for more than 60 days.

G. Orders:

a. Except in urgent situations, the intern writes all orders on inpatients.

b. Orders should be written as early as possible in the day.

c. Orders should be legible, precise, unambiguous, dated, and timed.

d. If a full set of admission orders cannot be written immediately, a brief set of preliminary orders needs to be written.

e. During the first three months of internship all admission, transfer, and discharge orders must be co-signed by the ward resident or attending physician.

f. Daily attention to drug renewal orders is required.

g. STAT or Urgent orders should be pointed out to the appropriate nurse.

h. All telephone or verbal orders must be cosigned AND timed/dated within 24 hours. Verbal orders should be kept to a minimum and are meant to be for emergent situations. Verbal orders are a privilege that can be denied if rules are not followed. You may sign a colleague's verbal order if you agree.

i. Do Not Resuscitate orders must be co-signed by the attending physician within 24 hours. Only a PGY2, 3, or a staff may write the initial order.

j. Orders after transferring a patient must be fully rewritten. Blanket orders such as "resume previous meds/orders" may not be used.

H. Restraints: PG1 residents may not order initiation or renewal of restraints. A PG2 or PG3 must do this.

I. Work Rounds: The ward or ICU resident leads work rounds with the intern, preceding Openers each day.

J. Attending Rounds:
   a. Each intern will be present for "Attending Rounds", which are held at the discretion of the attending. They may vary from three times per week on the ward teams to twice a day on the ICU team.
   b. Attending teaching rounds must include four and a half hours of teaching per week and include bedside teaching. Bedside teaching may include review of physical findings, bloodsmears and/or radiology studies as well as modeling patient interviews. Management rounds by the attending are not considered part of teaching rounds.
   c. The intern should be prepared to give a thorough, but succinct oral presentation on each new patient admitted to his/her service. These presentations should not be read from the chart. At the time of presentation, the intern should know the results of all laboratories, radiology studies, and ECG's as well as the patients' current medications.

K. Sign-out:
   a. Each intern must "sign-out" to the intern on call that will be covering his or her patients (as designated by the on-call roster) at the end of each day.
   b. Sign-out consists of informing the on-call intern of any problems to be expected with each patient overnight as well as code status. A written list of patients and problems must be provided to the intern on call.

L. Cross-cover:
   a. When on-call the intern is responsible for the management of urgent problems that develop in patients followed by other ward teams (if the intern is on ward call) or other ICU interns (if the intern on ICU call).
   b. The intern *must* carefully document any diagnostic or therapeutic interventions undertaken on such patients (i.e. cross coverage notes), and verbally inform the appropriate intern the next day.

M. Medical Students: The intern will help supervise medical students and ensure involvement in patient care. The senior resident is primarily responsible for medical student teaching although PGY-1 residents are encouraged to assist in this activity.

N. Work Limits: Each ward and ICU intern must receive a minimum of one day out of seven free from clinical duties (on average across four weeks). No ward or ICU intern may work more than 80 hours per week. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient continuity clinics and maintain continuity of medical care. No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care.

IV. **Teaching Conferences**

Each intern is required to attend all teaching conferences except in cases of emergent patient care. Attendance at these functions will be monitored and interns must sign-in on the attendance roster.

A. Core curriculum lectures are held at noon Mondays, Wednesdays, and Thursdays in the medicine department conference room. Grand Rounds is held Fridays at noon in the fourth floor conference room. Attendance is also required at Clinical Pathologic Conferences and Morbidity and Mortality Conferences.
B. Interns are required to attend "Morning Report," which is held each weekday at 0800 in the Medicine Conference Room.
C. Occasionally, interns will be expected to attend and present cases at other subspecialty conferences (e.g. Catheterization Conference, Chest Conference, Neuro Conference, Gl Conference, or at teaching conferences specifically designed for the interns).
D. Medicine PG1's are expected to attend Journal Club. Other interns rotating on medicine are welcome.
E. Intern Report is held every Tuesday at noon in the Heme/Onc conference room. Attendance is also mandatory.

V. **Outpatient Medicine Continuity Clinic**

A. From the outset of their PG1 year, interns begin seeing patients in their continuity clinics. This clinic will provide comprehensive, on-going care of ambulatory patients throughout residency. During this clinic, the intern will evaluate and plan the management of one new patient and see approximately three follow-up patients.
B. Interns are responsible for one to two half days of outpatient clinic per week while on the wards at DGMC, and one half day clinic while on the wards at UC Davis, or in the Emergency Department. Interns will see two half days per week while on outpatient rotations. No clinics will be scheduled while in the ICU.
C. Clinic schedules will be handed out for approval prior to the block. Any changes must be approved by the Chief of Residents. The form then must be returned to the scheduler.
D. Board-certified internists staff the continuity clinics (“clinic preceptor”). The intern should present each patient to the preceptor and discuss the plan for management before the patient leaves the clinic. The clinic preceptor reviews and co-signs the records of all patients seen by the intern.
E. The intern is responsible for maintaining a problem oriented outpatient chart on each assigned patient, including problem list, medication flow sheet, and progress notes. The completed charts must be given to the responsible clinic preceptor for review and co-signature by the end of the day.
F. The intern must review the results of any laboratory or radiographic studies requested on outpatients as they return to his/her CHCS mailbox and arrange for follow-up (i.e. additional tests, a return appointment, etc.).
G. The intern should check his/her CHCS mailbox and telephone consults (T-cons) in a timely manner for test results or messages from patients who may require assistance. T-cons should be answered in a timely fashion; ideally they should be answered the same day but at the latest within 48 hours.

H. Cancellation or rescheduling of clinics needs to be approved by the Chief of Residents.

VI. **Leave/TDY Policy**

A. Each Medicine PG1 resident is allowed three weeks of leave during the PG1 year. Leave should be projected at the beginning of the academic year. Leave may be taken during the Acute Medicine Clinic, Geriatrics, Cardiology and Women's Health Rotations or in special circumstances approved by the Chief of Residents. Leave is generally not granted during ER rotations.
B. Interns are responsible for notifying the Internal Medicine Clinic appointment scheduler of leave requests so clinic appointments are not scheduled during that time. This needs to be done at least 16 weeks in advance.
C. A leave coordination form must be obtained from the Department of Medicine training office and completed in full, including all necessary signatures before leave will be approved. All leave and TDY requests must be submitted at least four weeks in advance.
D. The intern must select a colleague to cover his/her outpatients while on leave (T-cons and other duties which might arise). This covering intern or resident must be assigned in CHCS as a surrogate provider to cover labs and T-cons. The front desk of the clinic must be notified of whom the covering resident is and a note should be taped to the intern's door with this information.
E. Requests for emergency leave should be made to the Chief of Residents and Program Director as soon as the need for such leave becomes evident.
F. Adjustments in work requirements, which become necessary due to illness or pregnancy, will be determined on an individual basis by the Program Director and Residency Education Committee of the Department of Medicine.
G. If the intern has a paper accepted for presentation at a scientific meeting every attempt will be made to allow attendance on TDY status.

VII. **Evaluations**

A. The intern should clearly understand what performance is expected of him/her at the start of each rotation (via these guidelines, by reviewing the curricula, and in conversation with the staff physician). As discussed earlier, goals and objective must be discussed and documented at the beginning of each block rotation. At the midpoint of each rotation the intern should be provided a verbal preliminary evaluation. At the end of each 4-week rotation, the intern will receive a written evaluation by the staff physician, which will be reviewed with the intern.
B. At least once during each ward rotation, the staff physician will observe each intern perform a complete history and physical examination (CEX or mini-CEX).
C. All interns must keep a procedure book summarizing all procedures performed including the patient's name, procedure, hospital ID number, date, indications, complications, and supervisor. Copies of all procedures should be submitted to the Department of Medicine residency coordinator.
D. All interns will take the ABIM In-training examination. This takes place in the fall. Do not plan to take leave during this time. This exam will not be used to formally evaluate the intern but should be used by the individual to assess his/her progress and depth/breadth of knowledge.

E. The Department of Medicine Residency Education Committee (REC) periodically reviews the performance of each intern. If it becomes apparent that an intern is not progressing satisfactorily, the REC, with the approval of the Program Director, may elect to provide that intern with more intense staff supervision and guidance in order to allow an opportunity for improvement in academic and/or clinical skills. If an intern is judged to have an unsatisfactory performance, the REC, with the approval of the Program Director, may place him/her on informal interdepartmental probation (i.e., "Academic Notice"), and establish a remedial program specifically designed to meet his/her special needs. If significant problems persist with an intern's performance, formal probation or even dismissal from the program may be recommended by the REC, the Program Director, and the Director of Medical Education (in coordination with the hospital Professional Education Committee), as outlined by Air Force regulation.

F. Each 4-week rotation all interns and residents are required to frankly and constructively critique their staff physician both at David Grant Medical Center and at University of California, Davis on the forms provided by the Chief of Residents.

G. Residents will formally meet with the program director twice a year for feedback sessions. Typically this occurs at the mid and end of the academic year. Any concerns about anything should be brought to the attention of the Chief of Residents, Associate Program Director or Program Director at anytime. We have an “open door” policy and welcome your questions or feedback.

VIII. **Research**

Residents must submit at least one abstract for a meeting or publication during their residency. Residents should expect to attend one funded scientific meeting during their residency. If the resident has a paper accepted for presentation at a scientific meeting, every effort will be made to allow attendance on TDY status.

IX. **Advisors**

Residents must pick an advisor from among the medical staff within the first three months of internship. They will meet with their advisor at least twice a year to discuss evaluations, research projects, career objectives, and fellowship applications among other things. Ideally this should happen in the first and third quarter.

X. **Outside Employment**

"Moonlighting" (i.e. outside employment in a medical position) by any house officer is not allowed.

XI. **Mandatory Part III of USLME or COMLEX**

All interns are required to pass part III of their USLME or COMLEX examinations during their PG 1 year. If you fail this exam you can take it again, but will need to pass this exam to go on to your PG 2 year. Please schedule yourself early in the year to take this exam and let the Chief of Residents and Clinic Scheduler know 8 weeks in advance so your clinics can be blocked.

Christina Humberd, Capt, USAF, MC
Chief of Residents 2003-2004

Heather Lorenzo, Maj, USAF, MC
Associate Program Director

Kathryn Amacher, Col, USAF, MC
Residency Program Director

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